PRINTED: 07/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
17E038 B. WING _							
	ROVIDER OR SUPPLIER D HEALTH AND REHAB			200 MAIN	RESS, CITY, STATE, ZIP CODE	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 222	partial extended surv complaint #KS00087			222			
F 223 SS=L	483.13(b), 483.13(c)(ABUSE/INVOLUNTA		F 2	.23			
		right to be free from verbal, mental abuse, corporal luntary seclusion.					
		use verbal, mental, sexual, rporal punishment, or					
	by: The facility had a cer residents selected for observation, interview facility failed to ensur to be free from physic entered resident #4's on the face and head floor, and then repea against the floor. Fac and did not physically approximately 5 minu beating resident #4 a #4 experienced seve transfer to a specialty expired on 6/8/15 fror resident #1. The facil develop/implement sinterventions to addression, facility faces	v and record review, the e each resident had the right cal abuse. Resident #1 room and beat the resident , pulled the resident to the tedly hit the resident's head ility staff witnessed the event v intervene. After tes, resident #1 stopped and left the room. Resident re injuries that necessitated v hospital. Resident #4 m injuries inflicted by ity's failure to			TITLE		(Ve) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DAT

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		17E038	B. WING			07/	24/2015
	NAME OF PROVIDER OR SUPPLIER HAVILAND HEALTH AND REHAB			20	TREET ADDRESS, CITY, STATE, ZIP CODE OO MAIN IAVILAND, KS 67059		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	intervene appropriate attacked another residents in immediat Based on observation review, the facility fail prevent abuse when increasingly agitated/he/she refused antips several weeks, and a physician in a timely rafter his/her behavior initiated two physical with residents within a resulted in his/her transpital. Findings included: Resident #1's clinic diagnoses of paranoid disorder characterized reality, disturbances of communication and fra thought process be influenced by anxiety irrational thinking) and abnormal emotional sexaggerated feelings emptiness and hopeled. The 1/14/15 Quarterly identified resident #1 impairment, no acute change, no hallucinat of care 4-6 days within period, no wandering	bow to deal with and residents, and failure to a resident physically dent, placed all facility be jeopardy. In, interview and record and to take sufficient action to resident #2 developed aggressive behaviors after sychotic medications for an anner of those refusals. The sescalated, resident #2 altercations (shoving/hitting) at 48 hour time period which ansfer to a mental health and record included deschizophrenia (psychotic descriptions) description of thought with the service of the point of depressive disorder (state characterized by of sadness, worthlessness, essness). In the resident physically developed and resident provided to the point of depressive disorder (state characterized by of sadness, worthlessness, essness). In the resident physically developed and resident physical physic	F	223			

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F 223	medication daily. The 4/6/15 Annual M with no cognitive imprental status change hallucinations and debehaviors directed to other behaviors which others at significant reinjury 4-6 days during period, improved behaviors, and use and antidepressant recommendation of the same of the	IDS identified resident #1 pairment, no acute onset per the presence of plusions, no physical poward others, the presence of the did not put the resident or pisk for physical illness or go the 7 day observation paviors compared to the prior per of antipsychotic, antianxiety predication daily. The sessments of the prior per of the prior per of antipsychotic, antianxiety predication daily. The sessments of the prior per of antipsychotic, antianxiety predication daily. The sessments of the prior per of antipsychotic, antianxiety predication daily. The sessments of the prior per of antipsychotic, antianxiety predication daily. The sessments of the prior per of antipsychotic, antianxiety predication for treatment of the predication for treatment of predication for treatment of the predic	F 223		

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F 223	Continued From page o "I take antipsychotic mental illness of para schizoaffective disord behavior or my behav contact the psychiatri o "Staff will check on and document on the o "I have behaviors o urinating/defecating of my room, ignoring sta until getting my way, and drinks. Staff to do are seen. Staff to red occur. [Family membrin behaviors. Psychia new/worsening behav o "I had a physical alt [male/female] peer or no further physical alt the next 90 days. I wi anger/upset at anyon Attempt to redirect if it	e 3 c medications due to my noid schizophrenia and ler. If I continue to display vior worsens, the staff will st." me at least every two hours clipboard" (4/23/14) f threatening peers/staff, on floor, eating/taking food to aff, going from staff to staff bumming cigs and money ocument behaviors as they irect behaviors as they er] to be notified of increase trist to be notified of viors." (2/18/15) tercation with a n previous night. I will have tercations with peers over Il talk with staff if I feel e over the next 90 days. noted to be getting upset ing fists, statements; notify		2223			
	resident to stay away who had resident alte health hospital] due to with another peer." (5 o "I readmitted from [to I became upset an with 2 peers and was hospital] on 5/7/15. I s	anger/behaviors. Encourage from [male/female] peer from [male/female] peer from [mental or increased anger/physical fi/6/15). In the second second second second second to [mental health will continue to display no cause physical harm to my					

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F 223	discharge goal. I will days. Resident contir interventions. Res. reanother physical alter contacted." (5/14/15) The care plan lacked and revised it with spresident #1's return fithospital on 5/14/15 to of increased physical directed at peers. Progress Notes inclusion of 5/6/15 at 5:45 p.m. incident that occurred walked by resident # the right side of the bafter the other reside pulled the resident to the guardian and physical of 5/7/15 at 12:49 p.m incident between resident that occurred profanity and then attresident. The facility then contacted a mere evaluate the resident of 5/7/15 at 4:25 p.m. completion of a ment qualified mental heal subsequent transfer treatment of increased interventions.	ental health hospital's] continue this for the next 90 nued with previously listed eminded that if [he/she] had reation, screener would be evidence that staff reviewed decific interventions upon rom the mental health of address the recent history aggression/physical contact ded the following: This entry described and diwhen another resident and tapped/hit him/her on rody. Resident #1 then ran not, grabbed his/her hair, and the floor. The facility notified resician of the incident. This entry described and ident #1 and another diwhen resident #1 yelled a tempted to "punch" the other notified the guardian and intal health screener to 's recent behavior changes. This entry described the al health screen by a	F 223		

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F 223	Continued From pag	e 5	F 2	23		
	hospital on 5/14/15. Evaluation" on the re on 5/14/15 described oriented, verbally ap content. The assess resident's history of a physical aggression, abusive, the present of antipsychotic, antimedications. Discharge notes dath health hospital noted hallucinations or delidischarge and no hor Discharge instruction. * Utilize free time by activities * Participate in theral healthy coping skills effective stress management of the previously described the previously described on 5/15/15 at 1:00 a.m. resident #1's refusal an assessment of ar	depression, history of history of being verbally be of hallucinations, and use anxiety, and antidepressant and bed 5/14/15 from the mental resident #1 reported no usions at the time of micidal or suicidal ideation. In a included: doing healthy, meaningful approximately py to learn and practice for various issues and agement. 1's care plan after acility on 5/14/15 revealed no wed/revised the care plan with bed discharge instructions. Notes after resident #1's di: In.: This entry described of vital signs and refusal of				

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F 223	resident's compliant and eating a meal in residents without into o 5/16/15 at 12:51 pepisodes of urinary and described the redaze." The note also "packed out" his/her all of his/her clothing hallway and then redaccording to the not to staff interaction o 5/17/15 at 1:40 a resident's compliant the evening shift and "walking in hall laug." Then, on 5/17/15 at included the following on duty at facility the attacked [another redof LE [law enforcem Contacted screener [mental health screen Later Progress Norecord dated 5/19/15/17/15 incident as a routine evening, we going to smoke breat are to supper medical walked on to room to minutes of walking as	the with taking medications in the dining room with other cident. I.m.: This entry described incontinence that morning, esident as "walks around in a codescribed how resident #1 room that morning and took grand room items into the turned them to his/her room. The received the ewith taking medications on described him/her as hing loudly." 8:45 p.m., a Progress Note are "Call received from nursing at resident (resident #1) resident]. Resident in custody ent] and transported to jail. who will complete screen	F 223		

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F 223	resident [resident #1] standing over [him/her repeatedly in the face nurse called 911. Thi off the bed head first [him/her] and banging floorAnother resider resident away." The facility completed previously described how resident #1 walk and began hitting him hands. According to the Licensed Nurse D he went to investigate the resident #1 standing striking the resident in Resident #1 to stop a assistance of other stresident #4 off the begin the face and head, resident's head again altercation between resident interesident interesi	art heard an unusual in investigation, observed this in [resident #4's] room, er] in bed, hitting [him/her] e and headwouldn't stop, is resident threw [resident #4] and continued hitting go [his/her] head against the ent intervened and got this ent intervened and entire facility's investigation, and an unusual noise and enter entire entire facility's investigation, and an unusual noise and enter entire enter ente	F 2	223		

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F 223	Continued From pag	ge 8 he day prior to the incident	F 223				
	between resident #1	and #4, noted that resident itory hallucinations on the day					
	the incident between staff for the afternoon two staff members, Care Staff E. Staffin month of May 2015	nedule for 5/17/15, the day of no resident #1 and #4, nursing on/evening shift consisted of Licensed Nurse D and Direct goschedules for the entire included assignment of 1 licensed nurse to the evening ghout the month.					
	Administrative Nurse	on 6/9/15 at 2:00 p.m., e C reported resident #4 om injuries received in the n resident #1.					
	Office Staff F reports (Crisis Prevention Ir year. Staff F also re instructor provided t them when several According to Staff F not take the CPI class	on 7/16/15 at 8:40 a.m., ed staff must recertify in CPI interventions) training each ported a contracted CPI he classes, and conducted people needed the class. , newly hired employees do ss prior to starting work at the liled in the first available class					
	Administrative Nurse CPI training in order resident behaviors a According to the CP Interventions) partic with a reprint date o	on 7/16/15 at 8:50 a.m., e C reported all staff received to know how to deal with and de-escalation techniques. I (Crisis Prevention ipant workbook dated 2005 f 2014, "The philosophy of the rovide the best care, welfare,					

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F 223	charge, even in violer proven effective in po The CPI workbook in Techniques", "Nonvio team intervention. Ol included: 1) Training staff with approaching and reduagitated person. 2) Focusing on the altronormal control and becomes 3) Instructing staff mecontrol their own anxiand maintain the best attitude. 4) Providing nonverbamessages that we traptich and pacing of or physical intervention maintain the best poswell as safety and seed during the most violer. The workbook directed or under-reaction. "Us to intervene with a very However, when the aphysical, you must als skills safe physical intervention the physical and During a telephone in	r the individuals in your not momentshas been stentially violent situations." cluded "Preventive lent Crisis Intervention" and objectives for trainees, seffective techniques in ucing the tension of an activation of ternatives if a person loses violent. The moments in techniques to eties during interventions at possible professional and paraverbal (the masmit through the tone, cur voices), verbal and skills to allow the staff to esible care and welfare, as curity, for all involved - even not moments. The distaff to avoid overreaction are verbal intervention skills rebally acting out person. The gression becomes so have in your repertoire of tervention techniques to cting-out behavior."	F	223			
	p.m., Administrative S	Staff A reported he/she s CPI trainer and learned the					

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F 223	physically intervene taught in the CPI may the facility decided "training staff how to there was concern with residents." Staff policies the facility presidents when they training that covered A, staff should call 9 violent and should not they awaited responsible. During an interview Administrative Nurse screener determined admission to a ment 2015 after he/she has with other residents. According to Nurse normally for him/her facility and on 5/17/1 not exhibit any signs readmission until the with resident #4. Nu no warning signs. [H#4]. Upon review of reported the facility of for 72 hours for resident #4 hours upon readmissions. Nu monitored resident #4 hours upon readmisprocess for all facility not verbalize any ad implemented upon readmission to address.	facility staff the methods to when a resident is violent as inual. According to Staff A, 3, 4 or 5 years ago" to stop intervene physically because vith the "size and strength of A could not verbalize what ut into place to handle violent stopped providing CPI I that area. According to Staff 11 if a resident became ot intervene physically while se from law enforcement. On 6/9/15 at 4:10 p.m., as B reported a mental health in early May and two physical altercations within a 24 hour time period. B, resident #1 behaved upon readmission to the 15, the day of the incident, did to f aggression after a time of the beating incident rese B reported, "There were be she] just attacked [resident the clinical record, Nurse B completed charting every shift dent #1 upon readmission on facility's standard process for the gresidents. Nurse B could ditional interventions	F 223			

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F 223	Continued From page	e 11	F 22	23			
	Licensed Nurse D co evening shift on 5/17, between resident #1 reported resident #1 through the early hou #1 took his/her medic down for awhile. A sh went out to smoke wi member and had no Nurse D saw residen after smoking. A shor strange noise coming South hallway and we reported he/she stopp room where the noise resident #1 beating re with clenched fists. A did not enter the roor stop. In response to t stopped beating resid stared blankly at Nurse beating. Nurse D call other staff member w Staff E. As Nurse D to Station to call 911, he resident #4 onto the f head against the floo Nurse D went back to where Direct Care St also stood at the doo he/she and Staff E re stop, but the resident requests and kept be estimated the continu- minutes" before anot resident #1 from the of	In 7/16/15 at 9:46 a.m., infirmed he/she worked the 1/15, the night of the incident and resident #4. Nurse D acted normally for him/her are of the shift. After resident cations, he/she went to lay nort time later the resident the other residents and a staff behaviors during that outing. It #1 return to his/her room that time later Nurse D heard a grom somewhere in the cent to investigate. Nurse D ped outside of resident #4's exame from, and observed exident #4 on the face/head ccording to Nurse D, he/she in but yelled at resident #1 to that request, resident #1 to the out for help from the corking that shift, Direct Care turned to go to the Nurses exhe saw resident #1 throw floor and start beating his/her r. After he/she called 911, the scene of the incident aff E and several residents rway. Nurse D recalled that the peatedly told resident #1 to did not respond to their ating resident #4. Nurse D and beating lasted "a good 5 ther resident called out to doorway and convinced and resident #4. At that time					

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F 223	to his/her own room. staff members or any resident #4's room of described incident, to his/her room. Nursenforcement approxithe facility after he/sl because they had to several miles away. not physically interve because of fear resident would leave deal with the situation residents. Nurse D sme it would make this I did (attempt to interthe facility's initial invincluded a statement physically removed room in order to stop reported that no one entered resident #4's incident. Licensed N completed CPI training but failed to complet offered it in March 20 he/she lacked currer. As requested, the faremployees (as of 7/2 and ANE (abuse, neall staff. According to current staff member the last year, including nurse who worked of beat resident #4. Als 32 current staff lacked.	ent #4's room and went back Nurse D recalled that neither y residents ever entered uring the previously intil after resident #1 returned se D estimated it took law imately 10 minutes to get to the placed the 911 call drive from another town Nurse D reported he/she did thene during the incident dent #1 would hurt him/her, to only one staff member to on and take care of the tated, "All my instincts told ings worse for more people if the physically)." Although the stigation into this incident at that another resident the sident #1 from resident #4's to the beating, Nurse D on, neither residents or staff, the room during the entire turse D reported he/she ong annually for many years, the training when the facility on 15. Nurse D confirmed	F 223				

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F 223	Care Staff E, the other the time of the incider training within the pass of the time of the incider training within the pass of the facility Unmanageable Resist Prevention Intervention and yonly be used if a physically aggressive skills must be used at the facility's "Abuse I with a revision date on "The facility administration committed to protection anyone including, but facility staff, other resist volunteers, staff from services to our reside guardians, surrogates or any other individual program provides pol governmandated staff programs that include identification and report of the facility failed to eright to be free from provided to develop and individualized intervention facility from a mental he/she underwent every physical aggression. Trained staff availale to	er staff member on duty at att, completed CPI and ANE at 12 months. Ity's current, undated dents" policy, "Crisis on physical control positions resident becomes Verbal crisis prevention at all other times." Prevention Program" policy of September 2012 included, ation and employees are not necessarily limited to: idents, consultants, other agencies providing ants, family members, legal as, sponsors, friends, visitors allThe abuse prevention icies and procedures that aff training/orientation as abuse prevention, orting of abuse" Insure each resident had the obysical abuse when staff implement specific, antions related to aggression anis/her readmission to the health hospital where aluation and treatment for The facility failed to have of address violent residents. These facility	F2	223		

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		17E038	B. WING		07/24/2015		
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F 223	The facility abated the 7/22/15 at 3:15 p.m. following measures: 1) Revised admission include special assess resident's histories of and diagnoses of traction of the facility cut of violent behaviors and development and implication individualized care put those behaviors. 3) Completed CPI tractions who were the two staff members who were the facility and the clock, with plans when resident behaviors when resident behaviors. 5) Revised the facility "unmanageable resident practice renession" - Resident #2's clinication medical diagnoses in disorder (a condition experiences a combine stage of the facility and t	e immediate jeopardy on by implementing the n screening polices to sement of prospective of previous violent behaviors umatic brain injuries. ent resident's clinical records arrent residents with histories and/or aggression, and them polementation of lans/interventions to address anding for all but two staff unavailable for training. The ill receive CPI training on levels to ensure that two CPI on duty at all times, around for additional staff support iors/needs require increased y policy for how to handle dents." the immediate jeopardy, the nained at a scope/severity of cal record included multiple acluding schizoaffective	F 223				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		17E038	B. WING _			C 07/24/2015	
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F 223	characterized by inversional state characterized by a greating) and depress emotional state charactering of sadness, and hopelessness). The 3/26/15 Annual identified resident #2 impairment, no acute change, the presence not directed toward of 7 day observation per hallucinations and dedirected toward othe observation period, but or others at risk for period of inattention, disorginto space as part of mental illness of sche Resident with behaverying loudly when period to the period of th	nania or depression), at (a neurological disorder bluntary cry or uncontrollable aughing or other emotional (any major mental disorder ross impairment in reality ive disorder (abnormal acterized by exaggerated worthlessness, emptiness MDS (Minimum Data Set) with no cognitive e onset of mental status e of behavioral symptoms others 1 to 3 days during the eriod, the presence of alusions, behaviors not rs 1-3 days during the 7 day behaviors did not put resident hysical illness/injury. seessments) completed after included the following: at with long standing displays anized thinking and staring behavior displayed with izoaffective disorder. iors of yelling, laughing and acing in hallways at times. tanding refusal to have labs efusing to bathe. Resident's ce resident or peers in his time.	F 2	23			
		on MDS identified resident impairment, the presence of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		OMPLETED	
		17E038	B. WING _			C 07/24/2015
	ROVIDER OR SUPPLIER DHEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	,	3172 H2010
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	Continued From pag	e 16	F 2	23		
	delusions, the presentoward others, behave	e of hallucinations and nce of behaviors not directed viors did not put the resident hysical illness or injury, and and antidepressant				
	CAAs (Care Area As 6/16/15 included:	sessments) completed on				
	to self/unseen persor refusing medications delusional statement not place self or othe time. Resident with lour listed behaviors and residents usual routing purposeful such as we bathing. At times behaviors. Resident wit illness and displays to illness. Resident's becontrolled when outs as "normal" in comm similar behaviors and feel embarrassed. Fawith behaviors and to behaviors. Will conresident's behaviors. behaviors, attempt to behaviors when they notified of new or wo to determine if medic warranted. At this tim however IDT [interdistanted.	of pacing in hallway, talking hs, yelling/crying loudly, hallucinations and voicing so Resident's behaviors do are in immediate threat at this ong-standing displays of have become part of he. At times behaviors are when refusing medications or haviors without any noted in long-standing mental behaviors associated with the haviors unable to be ide facility as not accepted unity. Resident's peers with the dithical lower resident to not accility staff trained to deal echniques for de-escalation intinue to care plan for Staff to monitor for redirect and document occur. Psychiatrist to be resening behaviors occurring the no referral indicated, sciplinary team] will continue to consult with healthcare				

NAME OF PROVIDER OR SUPPLIER HAVILAND HEALTH AND REHAB REGULATORY OR ISC IDENTIFYING INFORMATION) F 223 Continued From page 17 The 5/29/13 care plan for resident #2 included: o "Inappropriate behavior related to schizoaffective disorder and depressive disorderdocument behaviors in soon as occurs, remind resident of need to take medication and comply with careplan to work towards move out goal. Try different staff to try to get resident to take medications, bathe or allow lab to be drawn." The care plan lacked specific interventions related to provide multiple medications to resident #2, including: o Invega, an antipsychotic medication, 6 mg (milligrams) 2 tablets daily for unspecified psychosis (5/5/15 order) According to the March 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		
NAME OF PROVIDER OR SUPPLIER HAVILAND HEALTH AND REHAB (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG F 223 Continued From page 17 The 5/29/13 care plan for resident #2 included: o "Inappropriate behavior related to schizoaffective disorder and depressive disorderdocument behaviors in soon as occurs, remind resident of need to take medication and comply with careplan to work towards move out goal. Try different staff to try to get resident to take medications, bathe or allow lab to be drawn." The care plan lacked specific interventions related to physical aggression directed toward other residents. MARS (Medication Administration Records) directed staff to provide multiple medications to resident #2, including: o Invega, an antipsychotic medication, 6 mg (milligrams) 2 tablets daily for unspecified psychosis (5/5/15 order) According to the March 2015 MAR, resident #2 refused the Invega 1 time during the month. According to the April 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month.		C	
CA41ID SUMMAPY STATEMENT OF DEFICIENCIES PREPIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREPIX REGULATORY OR LSC IDENTIFYMG INFORMATION) PREPIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREPIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREPIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREPIX TAG F 223 Continued From page 17 F 223 F 223 The 5/29/13 care plan for resident #2 included: o "Inappropriate behavior related to schizoaffective disorder and depressive disorderdocument behaviors in soon as occurs, remind resident of need to take medication and comply with careplan to work towards move out goal. Try different staff to try to get resident to take medications, bathe or allow lab to be drawn." The care plan lacked specific interventions related to physical aggression directed toward other residents. MARS (Medication Administration Records) directed staff to provide multiple medications to resident #2, including: o Invega, an antipsychotic medication, 6 mg (milligrams) 2 tablets daily for unspecified psychosis (5/5/15 order) According to the March 2015 MAR, resident #2 refused the Invega 1 time during the month. According to the April 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month.	NAME OF DE	07/24/2015	
NAVILAND, KS 67059 CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PREF			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 223 Continued From page 17 The 5/29/13 care plan for resident #2 included: o "Inappropriate behavior related to schizoaffective disorder and depressive disorderdocument behaviors in soon as occurs, remind resident of need to take medication and comply with careplan to work towards move out goal. Try different staff to try to get resident to take medications, bathe or allow lab to be drawn." The care plan lacked specific interventions related to physical aggression directed toward other residents. MARs (Medication Administration Records) directed staff to provide multiple medications to resident #2, including: o Invega, an antipsychotic medication, 6 mg (milligrams) 2 tablets daily for unspecified psychosis (5/5/15 order) According to the March 2015 MAR, resident #2 refused the Invega 1 time during the month. According to the May 2015 MAR, resident #2 refused the Invega 4 times during the month. According to the May 2015 MAR, resident #2 refused the medication 4 times in the first 4 days	HAVILAND		
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of the month. o Mirtazapine, an antidepressant medication, 15 mg daily for depressive disorder			
According to the March 2015 MAR, resident #2 refused the medication 1 time during the month. According to the April 2015 MAR, resident #2			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059		
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F 223	refused the medication month. According to the May refused the medication of the month. o Simvastatin, a medication of the month. o Simvastatin, a medication of the Marrefused blood chole. According to the Marrefused the medication month. According to the May refused the medication of the month. o Benztropine Mesyl to treat involuntary meffects of certain psy pseudobulbar affect. According to the Marrefused the medication month. According to the Aprirefused the medication month. According to the Aprirefused the medication month. According to the Marrefused the medication month.	on 17 times during the 2015 MAR, resident #2 on 3 times in the first 4 days dication used to lower blood o mg. daily for hyperlipidemia esterol), ch 2015 MAR, resident #2 on 1 time during the month.	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 223	disorder, 25 mcg (n hypothyroidism (an According to the Aprefused the medical According to the Marefused the medical of the month. Review of resident notes, physician's crevealed no evident of the resident's included to manage Progress notes date included frequent donurses related to remedications and increfusals of medications and incref	dication used to treat a thyroid nicrograms) daily for underactive thyroid gland) ril 2015 MAR, resident #2 tion 3 times during the month. ay 2015 MAR, resident #2 tion 2 times in the first 4 days #2's clinical record (progress orders, faxes to the physician) reasing refusals of ing refusals of ing refusals of medications at the symptoms of psychosis. and from 4/1/15 to 5/7/15 pocumentation by licensed sident #2's refusal of the preasing behaviors, including: ons on April 5, 8, 18, 21, 22, 29 and 30, 2015. Resident #2 as follows: and packed clothing and a trash bin dent paced and yelled on the ked loudly with an agitated	F 23	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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		17E038	B. WING			07/	24/2015
	ROVIDER OR SUPPLIER HEALTH AND REHAB			20	TREET ADDRESS, CITY, STATE, ZIP CODE DO MAIN AVILAND, KS 67059		
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F 223	laughed. o 4/27/15: Staff noted bedroom crying. o 4/28/15: Staff noted crying loudly and ther The resident also refu "There's snakes in the o 4/29/15: Resident # made "random statem o 4/30/15: Staff found his/her bed with the d corridor. Later, staff n halls and laughed. o 5/1/15: Resident #2 because they had sna o 5/2/15: Resident #2 made loud, "quick" staunderstand. o 5/3/15: Staff noted r "stood and stared" and due to snakes in them o 5/4/15: Resident #2	resident #2 sat in his/her resident #2 had periods of had occasional laughing. sed medications because em." 2 paced the hallways and hents." resident #2 laying naked on oor open to the main oted the resident paced the refused medications akes in them. paced the hallways and etements that staff could not resident #2 paced and dagain refused medications	F:	223	DETIGIENCY		
	[7:55 p.m.] this reside	At approximately 1955 nt violently shoved/pushed get out of my [expletive]					

PRINTED: 07/29/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 223	feet away. Continued out of her wayWr nurse) on duty. [Parel agreement for placem med adjustments. Co instructed this nurse the resident to [acute psy availablecontacted facility] and waiting or The clinical record lad supervision/monitorin demonstrated physical another resident as parel Additional progress in the control of the progress of of	went approximately 12-15 yelling for [him/her]to get iter notified RN (registered int] of resident notified and in nent in another facility for intracted screener who then to fax information on inchiatric unit]no bed [another acute psychiatric in return call. Sked evidence of increased g of resident #2 after he/she al aggression against reviously described. This entry described an ined on 5/6/15 at 5:45 p.m. irroached another resident ent without provocation. Irress Notes dated 5/7/15 at lealth screener evaluated mined he/she required	F	223				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 223	Continued From page		F 2	23			
	during that same time included no evidence appropriate intervent behaviors until the reassaulted/abused two During observations 6/10/15 at 8:00 a.m., paced the hallways. conversation with other and did not exhibit signary and interview of Administrative Staff A clinical record lacked notification of his/her of medications during early May, 2015. Staclinical record lacked an increase in reside during that same time A confirmed resident two residents in early contacted a mental h transferred the reside Staff A presented a dresident #2's psychia	eperiod. The clinical record the facility implemented ions to address resident #2's sident physically o residents. on 6/9/15 at 2:25 p.m. and resident #2 continuously The resident did not initiate ters during the observations gns of aggression/violence. on 7/16/15 at 9:00 a.m., a reported resident #2's evidence of physician increasingly frequent refusal g the months of April and off A also confirmed the evidence that staff reported on behaviors to the physician e period. Administrative Staff #2 became physical with May 2015, and then staff					
	•	when staff informed the uency of those notifications					
	Abuse" policy with a 2012, "The staff will of facility's policies, procesystems etc [etcetera resident abuseAs	ity's "Preventing Resident revision date of September continually monitor the cedures, training programs, all to assist in preventing sessing, care planning, and with needs and behaviors that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		17E038	B. WING			07/	24/2015	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 280 SS=D	problems and develop plans to address behave plans to address behave the provide increased more prevent abuse when I increasingly agitated/he/she refused multip antipsychotic medicat after staff failed to not manner of those refuse escalated, resident #2 altercations (shoving/a 48 hour time period transfer to a mental h 483.20(d)(3), 483.10(PARTICIPATE PLANITY The resident has the incompetent or otherwincapacitated under the participate in planning changes in care and to A comprehensive care within 7 days after the comprehensive assessinterdisciplinary team physician, a registere for the resident, and of disciplines as determined and, to the extent prathe resident, the residelegal representative; as the plans of the process of the resident, the residelegal representative; as the plans of the extent prathe resident, the residelegal representative; as the plans of the process of the resident, the residelegal representative; as the plans of th	r neglect; Assessing and symptoms of behavior bing and implementing fare avioral issues" ake sufficient action and unitoring and supervision to Resident #2 developed aggressive behaviors after alle medications, including aions, for several weeks, and aiffy the physician in a timely sals. After his/her behaviors a initiated two physical hitting) with residents within which resulted in his/her ealth hospital. k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to a care and treatment or treatment.		223				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E038	B. WING		C 07/24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB		20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 MAIN AVILAND, KS 67059	0772472013
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F 280	Continued From page	e 24	F 280		
	by: The facility had a ce residents selected fo observation, interview facility failed to review of 3 residents upon the toinclude specific an related to the aggres necessitated the resito include hospital dis (Residents #1 and #2 Findings included: Resident #1's clinical diagnoses of paranoid disorder characterize reality, disturbances communication and fathought process be influenced by anxiety irrational thinking) an abnormal emotional exaggerated feelings emptiness and hopel The 1/14/15 Quarterlidentified resident #1 impairment, no acute change, no hallucina of care 4-6 days with period, no wandering	w and record review, the w/revise the care plans for 2 heir return from the hospital d individualized interventions sion/violence that dents' hospitalizations and/or scharge instructions. 2) cal record included d schizophrenia (psychotic d by gross distortion of of language and ragmentation of thought with dieved to be heavily or fear to the point of d depressive disorder (state characterized by of sadness, worthlessness, essness). y MDS (Minimum Data Set)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER D HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	· :		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	Continued From page		F 2	80			
	with no cognitive impressed mental status change hallucinations and debehaviors directed to other behaviors which others at significant rinjury 4-6 days during period, improved behassessment, and use and antidepressant in CAAs (Care Area Ass 4/8/15 included: O Behaviors: "Resided displayed behaviors on conversations and often with diagnosis of Resident with behavistatements, auditory hallways. Resident's [him/her] or peers in Facility staff trained to de-escalation of behaviors of keeping to self and Schizophrenia and training psychotropic drug psychotropic medical schizophrenia. Psychfacility to evaluate medical schizophrenia.	elusions, no physical award others, the presence of h did not put the resident or isk for physical illness or g the 7 day observation haviors compared to the prior of antipsychotic, antianxiety medication daily. Seessments) completed on the with long standing of having difficulty focusing difficulty focu					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 280	mental illness of para schizoaffective disord behavior or my behavior contact the psychiatri o "Staff will check on and document on the o "I have behaviors or urinating/defecating or my room, ignoring state until getting my way, and drinks. Staff to do are seen. Staff to redoccur. Father to be not behaviors. Psychiatris new/worsening behavior	c medications due to my noid schizophrenia and ler. If I continue to display vior worsens, the staff will st." me at least every two hours clipboard" (4/23/14) If threatening peers/staff, on floor, eating/taking food to aff, going from staff to staff bumming cigs and money ocument behaviors as they irect behaviors as they otified of increase in st to be notified of viors" (2/18/15) tercation with a an previous night. I will have tercations with peers over ll talk with staff if I feel e over the next 90 days. In the control of the screened if see anger/behaviors. Encourage from [male/female] peer tercation. Screened to [mental or increased anger/physical	F	280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E038	B. WING		C 07/24/2015		
	ROVIDER OR SUPPLIER D HEALTH AND REHAB		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	1 0.1.2.1.2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
F 280	days. Resident contirinterventions. Res. reanother physical altercontacted" (5/14/15) The care plan lacked developed individuali upon resident #1's rehospital on 5/14/15 to of physical aggressio at peers. Progress Notes incluion 5/6/15 at 5:45 p.m. incident that occurred walked by resident # the right side of the bafter the other resident to the guardian and physical aggression at peers. O 5/6/15 at 12:49 p.m. incident between resident that occurred pulled the resident to the guardian and physical period in the guardian and physical period in the facility and then attresident. The facility then contacted a merevaluate the resident on 5/7/15 at 4:25 p.m. completion of a mention qualified mental healt subsequent transfer the treatment of increase	continue this for the next 90 nued with previously listed eminded that if [he/she] had reation, screener would be evidence of newly zed, specific interventions turn from the mental health of address the recent history in/physical contact directed ded the following: This entry described and divide when another resident and tapped/hit him/her on ody. Resident #1 then ran int, grabbed his/her hair, and the floor. The facility notified resician of the incident. This entry described and dent #1 and another divident #1 and another divident #1 when resident #1 yelled a tempted to "punch" the other notified the guardian and intal health screener to "s recent behavior changes. This entry described the all health screen by a	F 280				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E038	B. WING		C 07/24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB		20	TREET ADDRESS, CITY, STATE, ZIP CODE DO MAIN AVILAND, KS 67059	0112412013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 280	hospital on 5/14/15. Evaluation" on the re on 5/14/15 described oriented, verbally approntent. The assessing resident's history of a physical aggression, abusive, the presence of antipsychotic, antiamedications. Discharge notes date health hospital noted hallucinations or deludischarge and no hor Discharge instruction. * Utilize free time by activities * Participate in therage healthy coping skills effective stress manage and the previously described activities. Review of resident # readmission to the factive extress manage and the previously described activities. Additional Progress is readmission included to 5/17/15 at 8:45 p.m nursing on duty at factivities at 12 mounts of the factive	I from the mental health A "Nursing Admission sident's return to the facility I the resident as alert and propriate, pleasant and ment also noted the depression, history of history of being verbally e of hallucinations, and use anxiety, and antidepressant and 5/14/15 from the mental resident #1 reported no asions at the time of micidal or suicidal ideation. Is included: doing healthy, meaningful by to learn and practice for various issues and agement. 1's care plan after cility on 5/14/15 revealed no red/revised the care plan with bed discharge instructions. Notes after resident #1's I: "Call received from cility that resident (resident resident]. Resident in afforcement] and transported gener who will complete	F 280		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OMPLETED
		17E038	B. WING _			C 07/24/2015
	ROVIDER OR SUPPLIER DHEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	<u>'</u>	0172-42010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	Continued From pag	e 29	F 2	80		
	record dated 5/19/15 5/17/15 incident as for a routine evening, war going to smoke breat nurse reminded resident for supper meds walked on to room to minutes of walking at to med cart for HS [hat 1945 [7:45 p.m.]. at this time along wit p.m.] nurse at med collanging sound. Upon resident [resident #1] standing over [him/horepeatedly in the factures called 911. This resident] off the bed hitting [him/her] and	n investigation, observed this] in [another resident's] room, er] in bed, hitting [him/her] e and headwouldn't stop, is resident threw [other head first and continued banging [his/her] head nother resident intervened				
	Administrative Nurse screener determined admission to a menta 2015 after he/she ha with other residents of According to Nurse Enormally for him/her facility and on 5/17/1 not exhibit any signs readmission until the with resident #4. Nur no warning signs. [H #4]. Upon review of the screen admission of the screen admis	on 6/9/15 at 4:10 p.m., Be reported a mental health resident #1 required at health hospital in early May detwo physical altercations within a 24 hour time period. By, resident #1 behaved upon readmission to the 5, the day of the incident, did of aggression after time of the beating incident se B reported, "There were ele/she] just attacked [resident he clinical record, Nurse B completed charting every shift				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		17E038	B. WING _			C 07/24/2015	
	ROVIDER OR SUPPLIER D HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	<u>'</u>	0172472010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	5/14/15 which is the all readmissions. Numonitored resident # hours upon readmiss process for all facility not verbalize any addeveloped/implements/14/15 readmission of physical aggression. The facility failed to reare plan at the time on 5/14/15 to include goals/specific, individe to recent episodes of residents that necess mental health hospitareview/revise resider readmission to include from the mental health	ent #1 upon readmission on facility's standard process for rea B also reported staff 1's whereabouts every 2 sion, which is also the residents. Nurse B could ditional interventions ted upon resident #1's to address the recent history on toward other residents. eview/revise resident #1's of readmission to the facility appropriate measurable dualized interventions related aggression against other sitated hospitalization in a sal. The facility also failed to the facility also	F2	280			
	medical diagnoses in disorder (a condition experiences a combinallucinations and desymptoms such as measurements as the pseudobulbular affect characterized by inversiones of crying, ladisplays), psychosis characterized by a greating) and depression emotional state characterized.	in which a person nation of symptoms such as elusions, and mood disorder nania or depression), it (a neurological disorder oluntary cry or uncontrollable aughing or other emotional (any major mental disorder ross impairment in reality					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	· /	TE SURVEY MPLETED
		17E038	B. WING		۰.	C 7/24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	1 0	//24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	The 3/26/15 Annual identified resident #2 impairment, no acute change, the presence not directed toward of 7 day observation per hallucinations and dedirected toward other observation period, to or others at risk for period of the company of the	MDS (Minimum Data Set) with no cognitive conset of mental status e of behavioral symptoms others 1 to 3 days during the criod, the presence of clusions, behaviors not rs 1-3 days during the 7 day ochaviors did not put resident orbital illness/injury. sessments) completed after of included the following: cent with long standing n, disorganized thinking and orbital part of behavior displayed of schizoaffective disorder. ors of yelling, laughing and acing in hallways at times. canding refusal to have labs efusing to bathe. Resident's oce resident or peers in this time." on MDS identified resident impairment, the presence of cof hallucinations and once of behaviors not directed viors did not put the resident othysical illness or injury, and	F 28			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			X3) DATE SURVEY COMPLETED			
		17E038	B. WING			C 07/24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 200 MAIN HAVILAND, KS 67059		7772-472010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	to self/unseen persor refusing medications, delusional statements not place self or othe time. Resident with lours listed behaviors and laresidents usual routing purposeful such as we bathing. At times behaviors, Resident with illness and displays beillness. Resident's becontrolled when outsing as "normal" in common similar behaviors and feel embarrassed. Fawith behaviors and te of behaviors. Will convesident's behaviors, attempt to behaviors when they notified of new or work to determine if medic warranted. At this time however IDT [interdist to monitor and will conprofessional as needed. The 5/29/13 care plant or "Inappropriate behavior self-ective disorderdocument occurs, remind resident medication and computowards move out go get resident to take medication to take medication to take medication and to take medication and to take medication to take medication to take medication and to take medication and to take medication to take medication to take medication and to take medication to take medication to take medication and to take medication to take med	of pacing in hallway, talking as, yelling/crying loudly, hallucinations and voicing as. Resident's behaviors do rs in immediate threat at this ong-standing displays of have become part of the actions or aviors without any noted an long-standing mental behaviors associated with thaviors unable to be defacility as not accepted unity. Resident's peers with a this allows resident to not acility staff trained to deal achniques for de-escalation attinue to care plan for Staff to monitor for redirect and document occur. Psychiatrist to be resening behaviors occurring ation adjustment is e no referral indicated, aciplinary team] will continue ansult with healthcare ed.' In for resident #2 included:	F 28	30		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			1 50.25	_		(c
		17E038	B. WING			07/	24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB			20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MAIN IAVILAND, KS 67059		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	An interim care plan use from the mental health included: o 3 day charting due to o Vital signs every show the mental health included: o Vital signs every show the physical aggressive by physical aggressive by physical aggressive by physical aggression of immediately, notify psenforcement. The care plan development development increased monitoring recent history of aggregation address aggression lacked prevent additional aggregation address aggression lacked preventative in During observations of 6/10/15 at 8:00 a.m., paced the hallways. To conversation with other and did not exhibit signal provides of the provised after the provised after the provised after the provised signal provised sig	to physical aggression residents." upon resident #2's return h hospital dated 6/2/15 to readmission lift lication compliance fied of any adverse or lehavior due to history. If loccurs, place resident on 1:1 sychiatrist, notify law live law law live law	F	280			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		475020	B. WING				0
NAME OF P	ROVIDER OR SUPPLIER	17E038	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	07/	24/2015
HAVILANI	HEALTH AND REHAB			20	00 MAIN IAVILAND, KS 67059		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280 F 323 SS=J	toward other resident The facility failed to recare plan at the time on 6/2/15 to include a goals/specific, individ to recent episodes of residents that necess mental health hospita 483.25(h) FREE OF AHAZARDS/SUPERVI The facility must ensuenvironment remains as is possible; and each	eview/revise resident #2's of readmission to the facility appropriate measurable ualized interventions related aggression against other itated hospitalization in a l. ACCIDENT SION/DEVICES		280			
	by: The facility had a cer residents selected for and record review, the of 3 residents with ad supervision and inter accidents/hazards. Re incidents each of agg other residents which hospitalization at hose residents with mental resident's discharges to the facility, the facility	rventions to prevent esident #1 and #2 had two ression/violence against necessitated their pitals which treated illness. Upon both from the hospital and return lity failed to develop and e individualized, specific					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E038	B. WING				24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	<u> </u>		S1 20	TREET ADDRESS, CITY, STATE, ZIP CODE O MAIN AVILAND, KS 67059	<u> </u>	24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	including increased s protect all residents. resident #4 within thre readmission. Resider physical injury in the athose injuries. This deresident #4 in immediates in those injuries. This deresident #4 in immediates in the second included: Resident #1's clinic diagnoses of paranoid disorder characterize reality, disturbances of communication and from a thought process be influenced by anxiety irrational thinking) and abnormal emotional sexaggerated feelings emptiness and hopeled. The 1/14/15 Quarterly identified resident #1 impairment, no acute change, no hallucination of care 4-6 days within period, no wandering antipsychotic, antianamedication daily. The 4/6/15 Annual Mil with no cognitive impairmental status change hallucinations and debehaviors directed to other behaviors which	directed at other residents, upervision in an attempt to Resident #1 attacked see days of his/her at #4 experienced significant attack and later expired from efficient practice placed sate jeopardy. all record included deschizophrenia (psychotic deschizophrenia (F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 56.25.			(
		17E038	B. WING			07/	24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB			20	TREET ADDRESS, CITY, STATE, ZIP CODE DO MAIN AVILAND, KS 67059		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	period, improved beh assessment, and use and antidepressant m CAAs (Care Area Ass 4/8/15 included: o Behaviors: "Resided displayed behaviors on conversations and often with diagnosis on Resident with behavior statements, auditory hallways. Resident's landling or peers in i Facility staff trained to de-escalation of behavior of keeping to self and Schizophrenia and train o Psychotropic drug term psychotropic meschizophrenia. Psychfacility to evaluate meschizophrenia. Psychfacility to evaluate meschizophrenia and train o "I take antipsychotic mental illness of paraschizoaffective disord behavior or my behavior or my behavior or my behavior or my behavior on the psychiatric mental illness of paraschizoaffective disord behavior or my	at the 7 day observation aviors compared to the prior of antipsychotic, antianxiety dedication daily. The sessments of the standing of having difficulty focusing resident changes subjects of unspecified schizophrenia. The standing delayional delayions and pacing in the behaviors do not place deal with behaviors and eviors." The sessident is on long dedication for treatment of diatrist with monthly visits to edication regimen." The care plan included the design of the staff will st." The medications due to my moid schizophrenia and der. If I continue to display vior worsens, the staff will st."	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E038	B. WING		C 07/24/2015
	ROVIDER OR SUPPLIER DHEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 323	urinating/defecating of my room, ignoring state until getting my way, and drinks. Staff to deare seen. Staff to redoccur. Father to be no behaviors. Psychiatris new/worsening behaviors. I wanger/get at anyon Attempt to redirect if (pacing more, clench screener for resident increased escalation resident to stay away resident altercation. Shospital] due to increanother peer" (5/6/15) o "I readmitted from [to I became upset an with 2 peers and was hospital] on 5/7/15. I anger/aggression or opeers as this was [me	f threatening peers/staff, on floor, eating/taking food to aff, going from staff to staff bumming cigs and money ocument behaviors as they irect behaviors as they officed of increase in st to be notified of viors." (2/18/15) tercation with a an previous night. I will have tercations with peers over all talk with staff if I feel to e over the next 90 days. In the notified to be getting upset ing fists, statements; notify to be screened if see anger/behaviors. Encourage from female peer who had becreened to [mental health ased anger/physical with	F 32:	3	
	interventions. Res. re	nued with previously listed iminded that if [he/she] had reation, screener would be added the following:			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E038	B. WING		C 07/24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MAIN IAVILAND, KS 67059	0112412013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 323	o 5/6/15 at 5:45 p.m. incident that occurred walked by resident # the right side of the bafter the other reside pulled the resident to o 5/7/15 at 12:49 p.m incident between res resident that occurred profanity and then attresident. o 5/7/15 at 4:25 p.m. completion of a ment qualified mental heal subsequent transfer treatment of increase physical contact with hour time period. Resident #1 returned hospital on 5/14/15. Evaluation" on the re on 5/14/15 described oriented, verbally approntent. The assessing resident's history of cophysical aggression, abusive, the presence of antipsychotic, antiamedications. Discharge notes date health hospital noted hallucinations or delications or delications.	this entry described and when another resident and tapped/hit him/her on rody. Resident #1 then ran int, grabbed his/her hair, and the floor. This entry described and ident #1 and another did when resident #1 yelled a tempted to "punch" the other at health screen by a thin professional and to mental health hospital for ad agitation and increased two residents within a 24. If from the mental health A "Nursing Admission sident's return to the facility of the resident as alert and propriate, pleasant and ment also noted the depression, history of history of being verbally e of hallucinations, and use anxiety, and antidepressant and the design of the facility and antidepressant within a 24 anxiety, and antidepressant and the facility	F 323		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRU		(X3) DATE SURVEY COMPLETED			
		17E038	B. WING		C 07/24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB		20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 MAIN AVILAND, KS 67059	11242010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 323	evidence staff review include increased surbistory of aggression residents. Additional Progress readmission included on 5/17/15 at 8:45 p.m. nursing on duty at fa #1) attacked [another custody of LE [law et to jail. Contacted scr screen [mental healt of jail. Contacted scr screen [men	acility on 5/14/15 revealed no yed/revised the care plan to pervision due to the recent alviolence against other Notes after resident #1's d: n.: "Call received from cility that resident (resident resident]. Resident in aforcement] and transported eener who will complete the screen] in jail." e in resident #1's clinical at 2:44 p.m. described the involved #1 as follows: g a routine evening, walking going to smoke breaks. After nurse reminded resident to eart for supper meds. rese and walked on to room to ral minutes of walking around e to med cart for HS [hour of at 1945 [7:45 p.m.]. 1700 en at this time along with HS p.m.] nurse at med cart	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E038	B. WING _				C / 24/2015	
	ROVIDER OR SUPPLIER HEALTH AND REHAE			STREET ADDRES 200 MAIN HAVILAND, KS	SS, CITY, STATE, ZIP CODE S 67059		2472010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION NCH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	previously described how resident #1 wal and began hitting hi hands. According to Licensed Nurse D h went to investigate it resident #1 standing striking the resident #1 standing striking the resident Resident #1 to stop assistance of other resident #4 off the bin the face and head resident's head aga altercation between took place, Licensed responders" for assistance of other resident for assistance of other resident #1 from doing more Emergency medical another resident into #1 from doing more Emergency medical and sent him/her to helicopter. As of 5/2 investigation, reside in critical condition, mental health hosping Behavior monitoring nurses on 5/16/15, to between resident #1 resident #1 had audishift. The clinical record is supervision of reside from the mental hear related to the recent aggression/violence	ed an investigation into the dincident which described ked into resident #4's room m/her in the face with both the facility's investigation, eard an unusual noise and he origin. Nurse D found gover resident #4's bed, in the head. Nurse D yelled at and then called for staff. Resident #1 then pulled ed, repeatedly struck him/her d, and then banged the inst the floor. While the resident #1 and resident #4 d Nurse D called "emergency stance. Resident #1 peating resident #4 after ervened and "held" resident damage to resident #4. staff stabilized resident #4 an outlying hospital via 1/15, the date of the facility in the day prior to the incident and #4, noted the resident itory hallucinations on the day acked evidence of additional ent #1 upon his/her return lith hospital on 5/14/15 as	F3	223				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		17E038	B. WING				24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB		•	20	TREET ADDRESS, CITY, STATE, ZIP CODE DO MAIN AVILAND, KS 67059		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	facility residents and box under each reside According to Administinitialed the boxes we the residents when the that form. Although renot provide any other monitored/supervised after his/her readmiss. During an interview of Administrative Nurse expired on 6/8/15 from 5/17/15 incident with. During an interview of Administrative Nurse expired on 6/8/15 from 5/17/15 incident with. During an interview of Administrative Nurse screener determined admission to a mental admission to a mental admission to a mental authority of the facility and on 5/17/15 not exhibit any signs of readmission until the with resident #4. Nurse no warning signs. [Hew #4]. Upon review of the reported the facility of for 72 hours for reside 5/14/15 which is the fall readmissions. Nurmonitored resident #1 hours upon readmissions.	a document which listed all on which staff initialed the ent's name every two hours. It is name every	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		17E038	B. WING				C 24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB			2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MAIN IAVILAND, KS 67059		- 1120.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	physical aggression to verified increased support of the facility's "Abuse of with a revision date on "The facility administration committed to protection anyone including, but facility staff, other responding to the volunteers, staff from services to our reside guardians, surrogates or any other individual. This deficient practice immediate jeopardy where the properties of the protection of the protectio	ss the recent history of oward other residents and pervision of the resident. Prevention Program" policy of September 2012 included, ration and employees are not necessarily limited to: sidents, consultants, other agencies providing ents, family members, legal as, sponsors, friends, visitors als" Pe placed resident #4 in when the facility failed to esident altercations. Resident of aggression/violence ts which necessitated in at a mental health hospital. Eadmission to the facility on illed to develop and the individualized, specific to recent directed at other residents, upervision in an attempt to Resident #1 attacked the days of his/her in the tax and later expired from the immediate jeopardy on by implementing the in screening polices to	F	3323			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.125.			(
		17E038	B. WING			07/:	24/2015
	ROVIDER OR SUPPLIER DHEALTH AND REHAB			20	TREET ADDRESS, CITY, STATE, ZIP CODE DO MAIN AVILAND, KS 67059		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	and diagnoses of trau 2) Review of all curre in order to identify cur of violent behaviors a development and impindividualized care plathose behaviors. 3) Completed CPI tramembers who were used two staff members who were used two staff members with 8/1/15. 4) Evaluated staffing certified staff remained the clock, with plans of the clock, wit	previous violent behaviors imatic brain injuries. Int resident's clinical records reent residents with histories ind/or aggression, and them blementation of ans/interventions to address ining for all but two staff inavailable for training. The ill receive CPI training on levels to ensure that two CPI on duty at all times, around for additional staff support ors/needs require increased in policy for how to handle ents." The immediate jeopardy, the pained at a scope/severity of all record included multiple cluding schizoaffective in which a person mation of symptoms such as lusions, and mood disorder	F	323			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		17E038	B. WING			l	24/2045
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	<u> </u>		S 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MAIN IAVILAND, KS 67059	<u> 077</u>	24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	emotional state charafeelings of sadness, vand hopelessness). The 3/26/15 Annual Midentified resident #2 impairment, no acute change, the presence not directed toward of 7 day observation perhallucinations and dedirected toward other observation period, bor others at risk for place of the company of the	ve disorder (abnormal acterized by exaggerated worthlessness, emptiness MDS (Minimum Data Set) with no cognitive onset of mental status of behavioral symptoms thers 1 to 3 days during the riod, the presence of lusions, behaviors not s 1-3 days during the 7 day ehaviors did not put resident mysical illness/injury. sessments) completed after included the following: Int with long standing and part of behavior displayed schizoaffective disorder. For sor yelling, laughing and acing in hallways at times. For sor yelling, laughing and acing in hallways at times. For seriod and to be acing to bathe. Resident's the resident or peers in his time.:" In MDS identified resident mysical illness or injury, and	F	3323			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			DATE SURVEY COMPLETED
		17E038	B. WING			C
	ROVIDER OR SUPPLIER DHEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	I	07/24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 45	F 32	23		
	CAAs (Care Area As 6/16/15 included:	sessments) completed on				
	behaviors displayed to self/unseen persorefusing medications delusional statement not place self or othe time. Resident with listed behaviors and residents usual routi purposeful such as votathing. At times bel reason. Resident wit illness and displays lilness. Resident's be controlled when outs as "normal" in commismilar behaviors and to feel embarrassed. For with behaviors. Will coresident's behaviors, attempt to behaviors, attempt to behaviors when they notified of new or work to determine if medic warranted. At this tin however IDT [interdict to monitor and will corpofessional as need to Inappropriate behaviored and depressional and depressional and depressional as need to Inappropriate behaviored and depressional as need to Inappropriate and Inappropriate and Inappropriate Inappropriate Inappropriate Inappropri	o redirect and document of occur. Psychiatrist to be orsening behaviors occurring cation adjustment is ne no referral indicated, sciplinary team] will continue onsult with healthcare				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRU		(X3) DATE	SURVEY
		17E038	B. WING				C 24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB	1, 2000		200 MAIN	DRESS, CITY, STATE, ZIP CODE D, KS 67059	1 077	24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	different staff to try to medications, bathe or care plan lacked speephysical aggression or residents. Progress Notes for residents. Progress Notes for residents. Progress Notes for residents. Progress Notes for residents feet away. Continued out of her wayWinurse) on duty. [Pare agreement for placen med adjustments. Coinstructed this nurse resident to [acute psy availablecontacted facility] and waiting of 0.5/5/15 at 1321: Cor changedagrees to at another facility to a 0.5.7.15 at 12:16 a.m. happened on 5/6/15 approached another resident without proven A subsequent progreeresident #2's transfer on 5/7/15 for evaluating aggressive behaviors.	ion and comply with ards move out goal. Try or get resident to take in allow lab to be drawn." The cific interventions related to directed toward other desident #2 included: "At approximately 1955 and violently shoved/pushed get out of my [expletive]] went approximately 12-15 desident in approximately 12-15 desident in another facility for interior in another facility for interacted screener who then to fax information on invention and in ment in another facility for interacted screener who then to fax information on invention and in ment in another facility for interacted screener who then to fax information on invention in another facility for interacted screener who then to fax information on invention in another facility for interacted screener who then to fax information on invention in a continuous designation in the fact in a medications. In: described incident which at 1745 where resident #2 resident and struck that occation. So note documented to a mental health hospital on and treatment of	F	323			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		17E038	B. WING			·	24/2015
	ROVIDER OR SUPPLIER D HEALTH AND REHAB			S' 20	TREET ADDRESS, CITY, STATE, ZIP CODE OO MAIN AVILAND, KS 67059	<u> </u>	24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	hospitalization at a m treatment of physical other residents include o 3 day charting due to Monitor Vital Signs o Behaviors and med o Physician to be notiphysical aggressive be physical aggressive of 1:1 immediately, notifien forcement. The care plan development aggression lacked mindividualized, specific increased monitoring due to the recent histointerventions to prevene before it occurred. The only interventions to a occurred and lacked including the need for protect other resident. The clinical record lack supervision of resident related to the recent has aggression/violence as hospitalization for treatment for the facility provided a facility residents and box under each residents.	sion to the facility after ental health hospital for aggression directed toward led the following; to readmission every shift ication compliance lifed of any adverse or behavior due to history. If occurs, placed resident on by psychiatrist, notify law ped upon resident #2's neasurable goals and conterventions related to supervision of the resident ory of aggression, and ent additional aggression le revised care plan included address aggression once it preventative interventions increased supervision to see the supervision to see the supervision of the return the hospital on 6/2/15 as	F	3323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E038	B. WING			C 07/24/2015	
NAME OF PROVIDER OR SUPPLIER HAVILAND HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059	,	0172-42010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 323	REGULATORY OR LSC IDENTIFYING INFORMATION)		F 3:				
	facility staff, other revolunteers, staff from services to our reside guardians, surrogate or any other individu. The facility failed to padequate supervision accidents/hazards I incidents of aggressi residents which necessions.	n other agencies providing ents, family members, legal s, sponsors, friends, visitors als." provide resident #2 with n to prevent Resident #2 had two on/violence against other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7. Solesino		_	С	
		17E038	B. WING			07/2	24/2015
NAME OF PROVIDER OR SUPPLIER HAVILAND HEALTH AND REHAB				STREET ADDRESS, CITY, 200 MAIN HAVILAND, KS 67059			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	the facility failed to de appropriate individual related to recent agg	sion to the facility on 6/2/15, evelop and implement ized, specific interventions ression/violence directed at ding increased supervision	F:	323			
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE		F.	198			
	to demonstrate comp techniques necessary needs, as identified th	to care for residents'					
	by: The facility had a cer on interview and reco to ensure nurse aide certified nurse aides/of failed to participate in	ris not met as evidenced asus of 46 residents. Based and review, the facility failed competency when 5 of 9 certified medication aides ANE (abuse, neglect, upon hire and/or every 12					
	Findings included;						
	list of all staff membe aides and certified me included the dates the training. According to employed 9 nurse aid evidence of training a training within the pas	4/15 the facility provided a rs, including certified nurse edication aides. The list also e aides last received ANE that list, the facility es. Of the 9 aides, 5 lacked the time of hire and/or at 12 months as follows: Hired on 4/6/15 and no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E038	B. WING			C	
NAME OF PROVIDER OR SUPPLIER			D. Wille		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	24/2015
HAVILAND HEALTH AND REHAB					00 MAIN HAVILAND, KS 67059		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
F 498	since 3/4/14 o Direct Care Staff I: evidence of ANE train o Direct Care Staff J: evidence of ANE train During a telephone in p.m., Administrative Schanged ANE training year. Prior to the chartraining on ANE at the annually thereafter. A facility lacked current on some staff, and re have had the training documentation of it." The facility's "Abuse I with a revision date or "The facility administr committed to protectin anyone including, but facility staff, other res volunteers, staff from services to our reside guardians, surrogates or any other individual program provides pol	no evidence of ANE no evidence of ANE training Hired on 6/23/15 and no ning Hired on 7/2/12 and no ning terview on 7/14/15 at 5:15 Staff A reported the facility methods within the past nge, staff did "Silver Chair" to time of hire and then according to Staff A, the ANE training documentation ported, "We think more staff but we can't find the Prevention Program" policy of September 2012 included, ation and employees are ng residents from abuse by not necessarily limited to:	F	498			
	programs that include identification and repo						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		17E038	B. WING			C 07/24/2015	
NAME OF PROVIDER OR SUPPLIER HAVILAND HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAIN HAVILAND, KS 67059			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 498	The facility failed to e competency when 5 of aides/certified medical	ensure nurse aide of 9 certified nurse ation aides failed to buse, neglect, exploitation)	F 49	8			